III: Mental Health Initiatives as Peace Initiatives in Sri Lankan School Children Affected by Armed Conflict

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The Health Reach Sri Lanka project (1993-96) is described. It was a school-based assessment of children's exposure to war-related events and the presence of psychological distress, undertaken in six communities in parts of Sri Lanka variously affected by armed conflict. Its objectives, methods and results are presented. The research project aimed to raise national awareness of the psychosocial effects of armed conflict on children, using a community-development approach to local capacity building, based on the 'health initiative as peace initiative' model. As a follow-up to the study, a locally run programme, based on creative play and trauma-healing, was established, initially for the children involved in the study. This was later extended to other children in the district affected by armed conflict.

KEYWORDS: Children; Convention on Rights of the Child; Post-traumatic stress disorder; War trauma; Conflict; Sri Lanka

The recent generation of children and adolescents in Sri Lanka has been exposed to extensive social and military violence unprecedented in its modern history. In Sri Lanka, the armed conflicts since 1983 represent the single most debilitating and pervasive factor affecting the lives of children and women. Many children in Sri Lanka have witnessed the death or disappearance of family members and friends in the North and East ethnic conflict and during the Southern insurgency in 1987-89. Although accurate data are not available, it is estimated that over 500,000 children are directly or indirectly affected by the continuing conflict in the north and east.[1] Although considerable attention from non-governmental organizations (NGOs) has been directed at relieving malnutrition and health needs in the north and east, psychological needs following chronic violence are poorly understood and at the time of the study were without programming.

The initial intention was to explore the feasibility of a humanitarian ceasefire and vaccination campaign, modelled on successful initiatives in El Salvador and the Philippines, and building on proposals at the international conference on Humanitarian Cease-fires.[2] However, immunization coverage in Sri Lanka has been well maintained in even the most troubled areas. In contrast, the psychological needs of Sri Lankan children affected by armed conflict have received little attention. With few exceptions, government and NGO programmes addressing this problem are mainly social welfare interventions. The existing psychological counselling services in Sri Lanka lacked specific programming for children, and health and educational services did not consider the psychological status of the child in their policies and programming. Consistent with the overall goals and objectives of Health Reach, the Sri Lankan study sought to examine the links between armed conflict and psychological distress in exposed children at a community level.

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The project developed out of collaboration with a network of professional colleagues associated with recently established counselling centres for adult victims of torture and their families. The Sri Lanka study was a three-year (1994-96) partnership project between Health Reach and the Family Rehabilitation Center, Colombo; the research team consisted of community health medical professionals, psychological counsellors and child psychologists in Canada, the United Kingdom and Sri Lanka. The project made best use of the experience and acceptability at the community level of local partner organizations and sought to enhance their capacities throughout the project. Parallel to the study project was the exploration of appropriate community-based responses for the needs of improved psychosocial well-being and healing that would model a 'health to peace initiative'.[3] A full description of the project, the psychological study methods, results and recommendations, was printed and distributed in Sri Lanka.[4] A brief summary of the study and the Health to Peace Initiative is reported here with a critical analysis of the overall outcomes of the scheme.

Site Selection

Communities with histories of armed conflict or massacre (within the past five years) were selected in: Eastern Province, Batticaloa district (four Tamil communities, two Muslim, two non-Muslim); Polonnaruwa (two Sinhalese communities in the adjacent district affected by the ethnic conflict); and Kurunegala (two Sinhalese communities not directly affected by the ethnic conflict, but with local histories of civil violence and conflict during the JVP insurgency). The precarious security situation led to variable access to affected communities; the sampling is not necessarily representative of the larger ethnic population and results should not be extrapolated beyond the local communities. The study took place January to February 1995 during a temporary cessation of hostilities between the government of Sri Lanka and the Liberation Tigers of Tamil Eelam (LTTE).

Study Aims

The main aims of the study were to determine by using questionnaires, interviews and artwork, the degree and pattern of psychological distress in children. Building local awareness and training of interviewers through the survey project who could then use their experience to develop local projects were also considered important outcomes. The development of local capacity for peace building using 'health initiatives as peace initiatives' is described elsewhere.[3]

Methods

The study consisted of assessing a classroom of Year Six children in the eight communities. At each site, the fieldwork took place over a four-day period. A range of interview methods were used including questionnaires filled in by the interviewer, open-ended enquiry and artwork. The to provide adequate time for closure where traumatic memories proved interview style was supportive and care was taken to be non-intrusive and difficult. Formal interview time was approximately three hours for each child. Follow-up psychological support was arranged where necessary by an identified counsellor. For most subjects, there was a follow-up interview lift with their primary female caregiver (usually the mother) in the home setting. This allowed for validation of the children's experiences and the 1% gathering of relevant household information.

Summary of field study

- Day 1: One-on-one trust building: artwork of a neutral (non-conflict) scene; quantifying conflict exposure; definition of a traumatic event (most disturbing event for the child as they wish to disclose); artwork to represent this event and discussion of this; rest period if necessary; questions relating to psychological responses to this event; play programme and monitoring.
- Day 2: Re-establish relationship; enquiry into effects of previous day's Interview; questions relating to bereavement reactions (as relevant); questions relating to depression, low mood and somatization of distress, play programme and monitoring.

- Days 3 and 4: Public health screening (anthropometry, malnutrition screen, visual acuity); household interviews with primary female caregiver.

Sixty young female interviewers were trained over a seven-day period in a residential course in Colombo. Interviewers were selected on the basis of a proven commitment to local community work, and most had some relevant experience prior to training. They received follow-up training in their local community immediately prior to conducting the interviews in their local schools. Experienced professionals (including the authors) conducted the training. Topics included child development, psychological responses to trauma, interviewing skills, and use of questionnaires. The questionnaires were translated into Tamil and Sinhala and reviewed for suitability of concepts, word choice, and context in the local culture. During training the full interview format was pilot-tested over a two-day period with children from refugee camps of the same ethnicity as the interviewers. In addition the training workshops and field work sought to maximize inter-ethnic participation between Sinhala, Tamil and Muslim interviewers in what was often their first encounter with the other communities.

The fieldwork took place over eight to ten days for each of the Tamil and Sinhalese teams. Interviewers were housed communally to ensure adequate debriefing, confidentiality and information accuracy. Emotional support to the interviewers was essential; as many had been as affected by -the situations of violence as those they were interviewing.

Children completed questionnaire instruments for conflict-related exposures (Dyregrov A, Raundalen M, Stuvland A, War Trauma Screening Questionnaire: personal communication from Dr A Dyregrov), self-identified most traumatic event, and current symptoms and behaviours consistent with post-traumatic stress (Child Post-Traumatic Reaction Index CPTS-RI),[5-7] grief (UCLA Grief Questionnaire),[5-7] and depression,[8] using validated questionnaires. Home visits to interview the child's mother or primary caregiver included the Caretaker Version of the War Trauma Questionnaire, * and the Impact of Events Scale for post-traumatic stress in adults.[9]

Results

Three hundred and eight school children, mean age 11.4 years, were interviewed from selected classrooms, ranging from 29 to 49 students in size. There were appreciable differences in the general levels of war exposures and psychological trauma reported by children in the different schools.

Conflict-related exposures.
The War Trauma Questionnaire (see above) was used in child and parent I interviews to provide an inventory of key war-related experiences.

School disruption
More than half (58%) of the children had missed schooling because of the conflict, particularly in the Batticaloa district (91%) compared to 16%) in the other sites. The average length of disruption was one to five months. Eleven per cent had been forcibly separated from parents or caregivers for a period of over one-month. This included the child being sent elsewhere for protection, the caregiver being away for safety, or because of detention, or disappearance. Non-conflict separations, such as parents working abroad, were not included. Many cases of neglect and physical abuse in the home were present within the sample.

Exposure to armed conflict
Overall, 58% of the total sample reported that they were exposed to armed conflict such as shelling, shooting, bombing, etc.. In the area with the most intense history of conflict (Batticaloa), 89% of the children were exposed to war-related conflict, compared to 7% in Kurunegala and 15% it in Polonnaruwa. The interviewers were careful to exclude other forms of social violence from this definition.

Overall exposure to shooting at close distance was the most frequently reported experience with 40% of the total sample reporting this, often with multiple experiences. Forty per cent reported having gone into

hiding in bunkers or in the jungle to escape violence; 46% of children reported having been exposed to extreme poverty and deprivation due to war conditions for example, no home, food or water; 38% witnessed violence I to others such as someone being killed or injured or taken away ('disappeared') in the armed conflict.

Loss of family members

Thirteen per cent had a member of their family killed (in 4% of those interviewed this was a parent or sibling), 16% a member of their family disappeared and 13% a member of their family injured. The differences between communities were great with Batticaloa, where 14% were bereaved in this way, having the highest rate of mortality of a direct relation.

Personal experience of armed conflict

Twenty-five per cent of the children said they had personally been a victim of violence during the armed conflict. These children were concentrated in the Batticaloa sites (ranging from 9% to 63%). Of these 78 children, 76% experienced looting of their home, 49% were threatened with being killed $3 by someone, 56% were chased by armed persons. 22% described being beaten, 14% tortured, 12% arrested and 8% had been held in detention. Four per cent reported sexual abuse suggestive of rape. Eleven children (six boys, five girls, mean age at interview 12 years) reported torture, seven of which involved a kidnapping event.

Post-traumatic stress reactions

The questions that have been adopted by the World Health Organization in the International Classification of Diseases (ICD-10) are useful, and these are contained in the CPT-RI. The questions must relate to a particular traumatic event or events that have been personally experienced and involved actual or threatened death. All 308 children were screened; 88% of the survey sample had experienced such an event (78% conflict related and 10% non-conflict related such as domestic violence, burglary or drowning). Where such an event is identified and the psychological reactions to it are sufficiently severe, the person can be said to be suffering from post-traumatic stress disorder (PTSD). In general, a full PTSD description requires there to be intrusive memories of the event, avoidance of reminders of the event and physiological reactivity indicative of anxiety.

All children at risk were interviewed with the 20-question Child Post-traumatic Stress Reaction Index to assess for the presence of post-traumatic stress disorder.[6-8] Those scoring sufficiently high are considered to be likely to be suffering from PTSD. One-fifth of the school sample scored in a range that a clinician would normally consider to be a severe post-traumatic reaction, requiring intervention. Of the identified events 205 (78%) involved armed conflict, with a range in various communities between 30% to 100%; the remaining were non-conflict in origin (domestic violence, witnessing a drowning, home burglary, etc).

Children in the high trauma group were more likely to have: guilt related to the event (24%); had a family member injured, killed, or disappeared (75.9%); been him/herself a victim of violence (33.3%); and experienced separation from parents (14.8%); than those with a low score (6%, 41%, 18% and 9%, respectively).

Combining CPTS-RI and WTQ data, the conflict-related exposures correlated with the highest CPTS-RI scores included: mother/father disappeared (mean 43.3, S.D. 13.7); child's home looted (mean 35.4 S.D. 6.2); known person injured/ killed/ disappeared (mean 33.1, S.D. 12.1); mother/father killed (31.7, S.D. 10.9). On the other hand, witnessing violence to others, being forced into hiding or to change residence and more general exposures to armed conflict were less closely associated with high C-PTSD-RI scores.

Grief

Thirty-nine of the 308 children interviewed did not report any significant deaths or bereavement experience and therefore did not complete the questionnaire; 31% reported symptoms and associations with moderate grief levels, and 7% scored high. UCLA Grief score was positively correlated with C-PTSRI scores: those with high PTSD scores had grief scores more than twice those of low scorers. Birleson's Depression Inventory[8] was completed by 294 of the children. Nineteen per cent were considered to have symptoms constituting a problem, and 8% scored in the clinical range for which intervention is warranted. One-fifth of the children had felt that in the previous week life had not been worth living (one of the sub-items), and

several expressed suicidal ideation. Mean score for depression was more than doubled in those scoring high for PTSD compared with low scorers. Complaints of chronic stomach ache were also higher. Interpreting the results, it was recognized that many with post-traumatic stress reactions function well: witness the fact that all these children are attending school. In fact, maintaining a structured lifestyle and concentrating on distractions from difficulties (such as school work) is often protective and may be a constructive defence against high anxiety.

Dissemination of Results

The 50-page project report document[4] was distributed to approximately 200 key government figures, non-governmental organizations, agencies and individuals in Sri Lanka, and 100 in Canada and elsewhere. In addition to presenting the study's aims, methods and results, it presented background on the Convention on the Rights of the Child[10] recognizing psychological distress in children. The report advocated participatory and non-medicalized approaches to respond to the psychosocial needs of children. Recommendations consisted of practical ways to mobilize appropriate resources at a community level, highlighting the particular role of education system, teacher training, curricula and school policies such as corporal punishment practices.

The report document summarized the experience of conducting community-based research:

- Providing a safe and confidential environment for children was essential for each to 'tell their story'. Many acknowledged that this was the first time they had disclosed their difficult experience to someone. Most were eager to share their story with very little prompting. The study field-work should have the trained and caring individuals as a resource and support following the interviews.

- Using artwork during the interview enabled the children to express their feelings and emotions non-verbally. The process facilitated a bond of trust and sharing between interviewer and child in a series of discussions on the child's associations with their drawings.

- The children responded positively to local female interviewers. Children often remain silent in the presence of a middle-aged person out of respect for age and authority. Such people may also possess more rigid belief sets posing a barrier to impartial disclosure around issues of domestic and sexual violence. Likewise, male interviewers would not have been able to elicit candid responses from female heads of households around sensitive issues involving male violence.

- Ongoing support and contact with the children and families may be warranted for improved social functioning and sense of well-being. Recruiting and training personnel resources within the community can be an important step contributing towards local response initiatives. Given the scarcity of resources, research efforts should strengthen the capacity of local organizations.

- Medical or psychopathological labelling should be avoided in surveys of school children, or other natural population samples who are not voluntarily seeking medical, social or mental health services.

- The young adult women interviewers acquired an in-depth training in the concepts of PTSD, grief, anxiety and depression, which was approached through identifying and understanding their own personal traumatic experiences of the past. This proved to be a helpful and important experience for the interviewers themselves.

Despite occasional initial suspicion, interviewers were received with general acceptance at the schools and in the household interviews. Engaging the mothers in the process was valuable and often therapeutic. Some were reluctant to disclose incidents of rape, alcoholism and/or domestic violence to young, mostly unmarried, interviewers.

Developments since the Health Reach Project

Capacity building
In addition to the training and field experience of the sixty women interviewers eight went on to further formal training and subsequently have been employed in their fields.

Subsequent initiatives
A Sri Lankan development NGO mobilized a community-based follow-up in 106 communities in two of the three study districts (Polonnaruwa, Batticaloa), reaching over 14,000 women and children.[1] It involved 16 weekend camps each for over 200 children hosted by local rural schools, and facilitating multi-ethnic participation. The children slept away for two nights, met children from adjacent communities and shared games and experiences. Volunteer parents provided kitchen help. In the study site communities, Health Reach interviewers were recruited to help. The initiative was well received and deemed a major success; the programme will be extended as the Sarvodaya Shramadana Movement, and the project supported by USAID finding.

Education system
In the past year, Sri Lankan school curriculum policies have undergone a transition, introducing social literacy and personal development objectives. In the Batticaloa district, the school board has moved to develop play programmes in schools and is exploring alternative methods in the classroom.

Health initiatives as peace initiatives: the Butterfly Garden
Beyond the undertaking of a survey, one of the longer term objectives was to respond to the needs of children in zones of armed conflict with a community-based initiative to contribute to 'peace building' according to the paradigm of 'health initiatives as peace initiatives'.[3,11] With this aim, a community-based psychosocial intervention for children directly affected by war conditions was started in the study site of Batticaloa. The Butterfly Garden project (Vannathipoochi Poonga), has the dual objectives of trauma-healing at the child level and peace-building within the community.

The programme was modelled on the Spiral Garden, an innovative child play programme at the Bloorview MacMillan Centre, Toronto, Canada, a provincial centre for child physical rehabilitation. During the course of the Health Reach project, visits by Sri Lankan colleagues to Canada and workshops in Sri Lanka took place to adapt the model to the Sri Lankan culture and the setting of war affected communities. The donated site was renovated and began programming in September 1996 under the auspices of the Professional Psychological Counselling Centre of Batticaloa. Start-up funding was provided by the Canadian High Commission's Canada Fund, Colombo, with ongoing support from Humanistisch Institut Voor Ontwikkelingssamenwer Stiqhting (HIVOS), Netherlands.

Children are referred from schools and orphanages from various communities, reflecting the ethnic groups in the district: Tamil (Hindu, Christian) or Muslim. Approximately 150 children attend weekly for a six- to nine-month programme run after school and at weekends to develop their creativity through the visual and performing arts. The site is established as a 'peace zone', to provide children affected by armed conflict with a sanctuary where they can heal through engaging their creativity in play, artwork and earthwork. By making and mending in the Butterfly Garden they can become healers in their communities and in the world at large.

The objectives of the Butterfly Garden are:

- To pilot-test an innovative psychosocial intervention model for children affected by conflict-related violence, the principles of which may be adapted for other site-specific settings and needs throughout the world.

- To create imaginative tools that can be used at the village level to promote reconciliation and rehabilitation from trauma for children and their families.

- To promote a national exchange of ideas in the areas of art, environmentalism and healing on behalf of the children of Sri Lanka. Through the Butterfly Garden Circus to advocate peace-building, environmental awareness, public health and healing from trauma.

- To re-inspire the creativity, imagination and confidence of all people, but particularly the children in war-torn areas of Sri Lanka.

In its peace-enhancing goals, the programme plans to extend its presence in the communities over the course of the next two to three years as a child-focused process of creative revitalization and community reconciliation. This involves sensitization of teachers and parents to the psychological needs of distressed children; teachers have remarked that school performance and behaviour has dramatically changed in many of the children referred to the after-school programme.

In its therapeutic goals, the Butterfly Garden seeks to counter some of the effects of psychological trauma (which include depression, anxiety, loneliness and victimization) with fearlessness (as an expression of psychological comfort, well-being) and a sense of dignity, personhood and hope. The essence of this fearlessness is imparted through open communication and this communication manifests in many forms through engagement in the continuing creative process of the garden.

A 'trauma healing' programme has been developed in a quiet area for sit personal story telling called the 'Cuckoo's Nest', where innovative games and interview methods are used to facilitate trauma-healing. This involves one-on-one sessions with a trained and attentive counsellor. It combines healing meditations and rituals (earth-centred, universal, cross- denominational), and therapeutic interview techniques based on the child's genogram (kinship diagram) using cards and markers for events and situations appropriate to the social problems and living in a war zone. In such a setting, the game-like task through a guided interview

Application of the genogram in family therapy for adults is well described.[12] In such a setting, the game-like task through a guided interview to construct the child's genogram presenting household and family members, present, dead and absent, provides for disclosure and sharing. The genogram-based process provides a means to assess the child's emotional, cognitive and behavioural responses to recounting their life story, which often includes traumatizing experiences. Following the genogram session the child can engage in several creative activities with a staff animator who facilitates self-expression and psychological transformation. The child is reassessed at a later stage in the programme, so as to evaluate the effect of activities and the child's experience at the Butterfly Garden. An approach to evaluating the project's impact at the level of the child and the community is currently being developed, funded jointly by Sri Lanka Canadian Development Fund, Colombo, South Asia Partnership, Ottawa, and Primates World Relief and Development Fund, Toronto.

Critical Analysis of Health Reach Project

Evaluating the impact of war at the two levels of child and community involves a range of complex issues, such as sensitivity to the specific context of armed conflict in the local communities and how to respond to the psychological distress in children. This requires appreciating both sociocultural values and changes and disruption to this value system as a result of the armed conflict and widespread violence in the experience of the past -generation.

This was the first attempt at such a survey in Sri Lanka; there has been greater discourse on the psychological impact of the war on children, previously seldom mentioned, due in part to the direct and indirect effects of the project. Other major factors have been the resurgence of the war, with the capture of Jaffna in 1996, mass civilian casualties in the 31 January 1996 Colombo bomb blast, and shifts in international efforts to curtail the fighting and recognize the effect on children involved as child soldiers and as victims of armed conflict.

The short duration (three years only) of funding limited the ability to follow through with the recommendations and maximize the impact of the project. Longer-term funding arrangements are required

for optimum success for psychosocial and community development in zones of armed conflict. Funding policies should be reformulated for projects aimed at vulnerable children in need of protection under the Convention for the Rights of the Child, with efforts that can best strengthen local initiatives and partnerships to dev9lop and implement appropriate responses.

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